

CHAMPVA- Other Health Insurance (OHI) Certification

VA Health Administration Center

CHAMPVA

PO Box 65023

Denver CO 80206-9023

1.800.733.8387

Attention: After reviewing Page 2, complete form in its entirety (print or typewritten only) and return with required documentation only (do not enclose claims or correspondence). Limit entries to one character per block and do NOT exceed the designated space (i.e. do NOT extend last name into First Name area).

Section I - Beneficiary/OHI Information

Start with the sponsor's spouse and continue with all other CHAMPVA-eligible family members (regardless of OHI coverage). For each individual that had OHI coverage (excluding CHAMPVA) since becoming CHAMPVA eligible, be sure to complete the OHI information on the second and third line of each entry. If more than one OHI, continue on a separate sheet.

Spouse Information (if CHAMPVA-eligible)

Last Name	First Name	MI	Social Security Number	Have you had OHI since becoming CHAMPVA eligible? <input type="checkbox"/> yes <input type="checkbox"/> no (go to <i>Other CHAMPVA-Eligible Family Members' Information</i>)
OHI Policy Name	OHI Policy Number			OHI Phone Number (include area code)
Dates that OHI Covered		Is/was this a CHAMPVA-supplemental policy (see definition on Page 2)? <input type="checkbox"/> yes <input type="checkbox"/> no	Is/was this an FEHB policy (see definition on Page 2)? <input type="checkbox"/> yes <input type="checkbox"/> no	
Start Date (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)			

All Other CHAMPVA-Eligible Family Members' Information (if necessary, continue on additional 10-7959c and complete in its entirety)

Last Name	First Name	MI	Social Security Number	Have you had OHI since becoming CHAMPVA eligible? <input type="checkbox"/> yes <input type="checkbox"/> no (continue with next family member if applicable or go to Section II)
OHI Policy Name	OHI Policy Number			OHI Phone Number (include area code)
Dates that OHI Covered		Is/was this a CHAMPVA-supplemental policy (see definition on Page 2)? <input type="checkbox"/> yes <input type="checkbox"/> no	Is/was this an FEHB policy (see definition on page Page 2)? <input type="checkbox"/> yes <input type="checkbox"/> no	
Start Date (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)			

Last Name	First Name	MI	Social Security Number	Have you had OHI since becoming CHAMPVA eligible? <input type="checkbox"/> yes <input type="checkbox"/> no (continue with next family member if applicable or go to Section II)
OHI Policy Name	OHI Policy Number			OHI Phone Number (include area code)
Dates that OHI Covered		Is/was this a CHAMPVA-supplemental policy (see definition on Page 2)? <input type="checkbox"/> yes <input type="checkbox"/> no	Is/was this an FEHB policy (see definition on page Page 2)? <input type="checkbox"/> yes <input type="checkbox"/> no	
Start Date (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)			

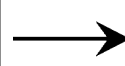
Last Name	First Name	MI	Social Security Number	Have you had OHI since becoming CHAMPVA eligible? <input type="checkbox"/> yes <input type="checkbox"/> no (continue with next family member if applicable or go to Section II)
OHI Policy Name	OHI Policy Number			OHI Phone Number (include area code)
Dates that OHI Covered		Is/was this a CHAMPVA-supplemental policy (see definition on Page 2)? <input type="checkbox"/> yes <input type="checkbox"/> no	Is/was this an FEHB policy (see definition on page Page 2)? <input type="checkbox"/> yes <input type="checkbox"/> no	
Start Date (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)			

Section II - Medicare Information

Are any individuals listed in Section I covered by:	1) First Name of Medicare-Eligible Beneficiary	Part A--Start Date (mm/dd/yyyy)	Part B--Start Date (mm/dd/yyyy)	Medicare Card Number
1) Medicare Part A? <input type="checkbox"/> yes <input type="checkbox"/> no				
2) Medicare Part B? <input type="checkbox"/> yes <input type="checkbox"/> no				
(If yes to <i>either</i> , attach copy of Medicare Card and complete this Section. If no to <i>both</i> , go to Section III.)	2) First Name of Medicare-Eligible Beneficiary	Part A--Start Date (mm/dd/yyyy)	Part B--Start Date (mm/dd/yyyy)	Medicare Card Number

Section III - Certification (to be completed by the beneficiary, sponsor, or legal guardian)

Federal Laws (18 USC 287 and 1001) provide or criminal penalties for knowingly submitting or making false, fictitious or fraudulent statements or claims.

 I certify that the above information is correct to the best of my knowledge and belief. If there should be ANY change in OHI status for the above beneficiaries, I will promptly notify VA's Health Administration Center. Sign and date on right, and complete the next two lines of information.			Signature		Date
Last Name		First Name	MI	Phone Number (include area code)	Relationship to Beneficiary(ies)
Street Address <input type="checkbox"/> check if new		City			State Zip Code

WHY THE OHI CERTIFICATION?

Except for Medicaid, State Victims Compensation Programs, and policies purchased exclusively for the purpose of supplementing CHAMPVA benefits (see *Supplemental Policy* definition), CHAMPVA by law is always the secondary payer of healthcare benefits. As part of our efforts to coordinate benefits among all involved insurance/benefit plans, completion and return of this OHI Certification is required.

THINGS TO RETURN WITH YOUR COMPLETED OHI CERTIFICATION

SEND PHOTOCOPIES...NO ORIGINALS PLEASE!

- ▶ If you used additional sheets of paper to record information that didn't fit in the space provided, be sure to enclose them.
- ▶ If any of the CHAMPVA beneficiaries identified in Section I are Medicare eligible, send us a copy of their Medicare Card.
- ▶ If your OHI is an indemnity policy (see definition), send us a copy of the policy.
- ▶ If your OHI does not issue EOBs, such as HMOs or plans that do not issue EOBs for specific type of claims, such as pharmacy claims, attach documentation of the OHI's plan coverage and copayment requirements.
- ▶ If your OHI does not cover a CHAMPVA covered benefit, send us documentation of the OHI's exclusions.

DEFINITIONS/ADDITIONAL EXPLANATIONS

EOB - the abbreviation for an explanation of benefits form. An EOB is a statement from an insurance carrier/benefit program that summarizes the action taken on a claim.

Expiration Date - this is the final date that your coverage was, or will be, in effect. If you are uncertain as to whether you will renew your OHI coverage, please leave *the Expiration Date* blank. If you later decide not to renew your policy, please contact us immediately.

FEHB - refers to coverage that is obtained through the Federal Employees Health Benefits Program, such as Blue Cross Blue Shield of Colorado, Postmasters' Benefit Program, etc.

HMO - refers to OHI that is provided through a health maintenance organization.

Indemnity Policy- includes those plans that pay a flat fee or daily rate for each day of hospitalization or a flat fee for a surgical procedure, regardless of actual cost.

OHI - the abbreviation for other health insurance.

Primary Policy- refers to a plan(s) that has primary payer responsibility when multiple coverage exists. Except for Medicaid and supplemental policies as defined below, CHAMPVA is always secondary payer when OHI exists. Examples of primary OHI include policies obtained through employment or privately purchased.

Sponsor - refers to the veteran upon whom CHAMPVA eligibility for the beneficiary is based.

Start Date - this is the *original* date your OHI policy went into effect - not the last renewal date.

Supplemental Policy - these are policies that are designed to pay only after the primary OHI, such as American Association of Retired People (AARP).

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Privacy Act: All information collected is subject to the provisions of the Privacy Act under 5 USC 522a. **Authority:** This information is solicited under 38 USC 501 and 1713; 10 USC 1086 (d). **Disclosure:** Disclosure is voluntary, but failure to provide the information may result in delay and/or denial of future CHAMPVA benefit claims. Failure to furnish this information will have no adverse impact on any other VA benefits to which the patient may be entitled.

Paperwork Reduction Act: This information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. Public reporting burden for this collection of information is estimated to average 6 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. The purpose of this data collection is to determine what secondary insurance is carried by the beneficiary.